

BOTOX[®] COSMETIC

Consent to Treat

Botulinum Toxin A injections involve a series of small subcutaneous injections designed to weaken certain muscles that cause wrinkling. Weakening of the injected muscles begins to be apparent after 2-3 days. Within 7-14 days, patients can expect to see the full effects of the treatment. Results typically last 3-6 months. Injections given at less than 3-month intervals may not produce a noticeable effect.

Please **review and initial** the following statements prior to your Botox Cosmetic™ treatment.

- I am not pregnant. I am not trying to get pregnant. I am not lactating (nursing). _____
- I do not have, or have not had, any major illnesses which would prohibit me from receiving botulinum injections. _____
- I certify that I do not have multiple allergies or high sensitivity to medications, including, but not limited to, botulinum injections. _____

Please **review and mark Yes/No** the following statements prior to your Botox Cosmetic™ treatment.

- Are you at least 21 years of age? Yes / No
- Have you ever received Botulinum Toxin A injections? Yes / No
- Are you taking any blood thinning medications? Yes / No
(Aspirin, Aleve/Ibuprofen, Lovenox, Coumadin, Plavix, Xarelto) Yes / No
- Do you have a history of neurological or neuromuscular disorder
(ALS, Lou Gehrig's, Myasthenia gravis, Lambert-Eaton Syndrome)? Yes / No
- Have you consumed alcohol within last 12 hours? Yes / No
- Do you have a history of cold sores or shingles? Yes / No
- Have you had a chemical peel within the last 24 hours? Yes / No
- Are you currently taking any autoimmune medications? Yes / No
- Are you currently taking any anti-malarial drugs (aminoquinolones)? Yes / No
- Are you taking any aminoglycoside antibiotics?
(Gentamycin, Polymycin, Spectinomycin?) Yes / No
- Are you taking Cyclosporine or D-Penicillamine? Yes / No

Please **review and provide a signature** for the following statements prior to your Botox Cosmetic™ treatment.

- I acknowledge that I might experience post treatment discomfort or bruising.
- I acknowledge that I might experience an allergic reaction.
- I understand that I might experience a rare post-treatment infection associated with any transcutaneous injection.
- I understand that no procedure is completely risk-free and that unforeseen risks may not be included on this list.

Print name: _____ Signature/Date: _____

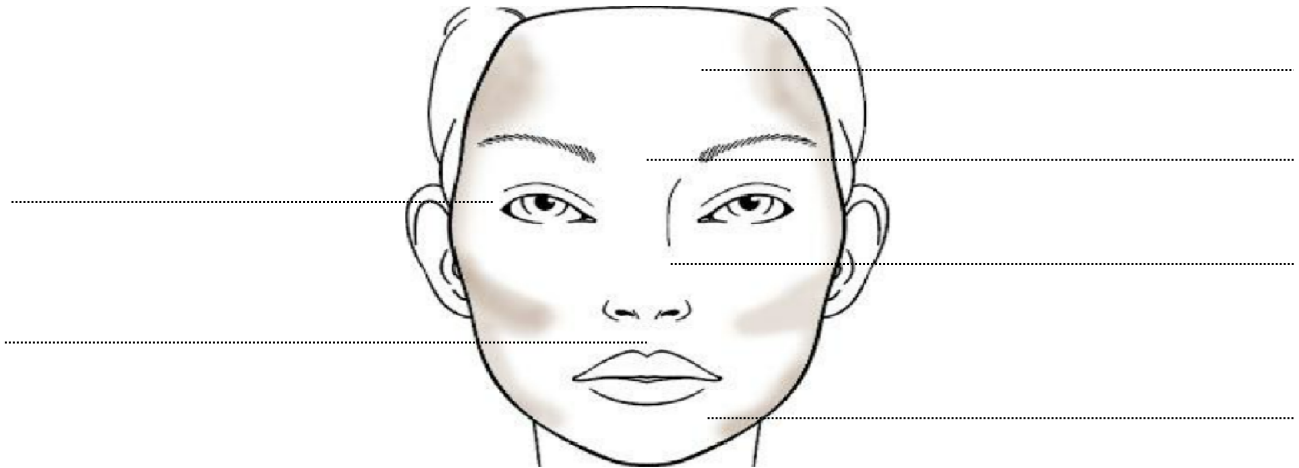
DISCLAIMER: Informed consent documents are used to communicate information about the proposed treatment of a disease or condition along with disclosure of risk and alternative forms of treatment. The informed consent process attempts to define principles of risk disclosure that should generally meet the needs of most patients in most circumstances. However, informed consent documents should not be considered all-inclusive in defining other methods of care and risks encountered. Informed consent documents are not intended to define or serve as the standard of medical care. Standards of medical care are determined on the basis of all of all the facts involved in an individual case and are subject to change as scientific knowledge and technology advance and as practice patterns evolve.

Patient Name: _____ FFC Beauty Staff Name: _____

Product Used / Lot #: _____ Treatment Date: _____

Total # of Units: _____ Expiration Date: _____

Area Treated	Frontalis Forehead	Glabellar Frown Lines	Lateral Canthus Crows Feet	Orbicularis Oris Lip Flip	Other Describe
Product + Notes, Narrative					
Amount: Units					



CLIENT INVOICE



PRODUCT/QUANTITY: PRICE TOTAL

Card			
Cash			
Other Payment Method			
Alle Discount(s)		-	-
FFC Discount(s)		-	-

Amount Paid